Journal of Mental Health
Publication details, including instructions for authors and subscription information:
http://www.informaworld.com/smpp/title~content=t713432595

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First Published on: 30 November 2007
To cite this Article: Awara, Mahmoud and Fasey, Christopher (2007) 'Is spirituality worth exploring in psychiatric out-patient clinics?', Journal of Mental Health, 17:2, 183 - 191
To link to this article: DOI: 10.1080/09638230701498390
URL: http://dx.doi.org/10.1080/09638230701498390

Journal of Mental Health,
April 2008; 17(2): 183 – 191

informa
healthcare

Is spirituality worth exploring in psychiatric out-patient clinics?

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Abstract

Background: The Royal College of Psychiatrists has advocated a collective approach when dealing with psychiatric patients including biological, psychological, social, and spiritual. Ignoring patients' religious and spiritual needs could be perceived as discrimination on basis of race, religion, and ethnicity. Moreover, it may hamper the psychological healing process of the patient.

Aims: To explore and measure the spiritual and religious beliefs and their impact, in psychiatric out-patients and to assess the demographic predictors for such beliefs. Furthermore to draw the attention of service providers to the spiritual needs of our patients.

Methods: All patients (103) attending psychiatric out-patient service for 3 consecutive months, were approached; 42% of them consented to the study. The Royal Free Interview for Spiritual and Religious Beliefs was employed. Chi-Square test, Kruskal Wallis, and MCE were used to examine the statistical significance of demographic characteristics of patients on their responses, whether from the spiritual or non-spiritual groups.

Results: Forty three (42%) patients participated in this study, 77% were females and 23% were males. Fifty percent considered themselves as spiritual, religious, or both, 39% were neither spiritual nor religious, and 12% did not verify themselves. The spiritual and religious patients were significantly older than those who were not spiritual or religious. The impact of spiritual and religious beliefs tends to be positively correlated with age. A majority of 54% felt that their spiritual/religious beliefs improved their coping strategies. In total 50% of our patients felt that their cultural values and beliefs were not taken into consideration by the service.

Conclusions: The study highlighted the importance of spiritual and religious beliefs to psychiatric out-patients, which unfortunately was either ignored or trivialized by the service providers and professionals.

Declaration of interest: None.

Keywords: *Spirituality, psychiatric out-patient*

Introduction

The religious and spiritual dimensions of life are among the most important cultural factors shaping human experience, beliefs, values, as well as illness behaviors (James, 1961); (Krippner & Welch, 1992). Until recently, health professionals have largely followed a medical model which seeks to treat patients by focusing on medicines and surgery, and gives less emphasis on beliefs and faith – in healing, in the physician and in the doctor – patient

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ISSN 0963-8237 print/ISSN 1360-0567 online
DOI: 10.1080/09638230701498390

relationship. Furthermore, mainstream psychiatry, in its different aspects; theory, research, practice, and its diagnostic classification system; has tended to either ignore or to pathologize the religious and spiritual issues that patients bring into treatment. This represents a form of cultural insensitivity which can be traced back to the roots of psychoanalysis as well as behaviorism and cognitive therapy. Freud perceived religion as a universal obsessional neurosis and a regression to primary narcissism (Freud, 1959). Skinner largely ignored religious experience, and Ellis saw religion as equivalent to irrational thinking and emotional disturbance. Similarly the Group for the Advancement of Psychiatry viewed religion as a primitive infantile state (Group for the Advancement of Psychiatry, 1976).

Surveys conducted in the United States consistently show that both the general public and psychiatric patients report that they attend church more frequently than do mental health professionals, believe in God at a significantly higher rate, and consider religion to have a more significant role in their life (American Psychiatric Association, 1975; Kroll & Sheehan, 1989; Shafranske & Malony, 1990). In addition, surveys of psychiatry and psychology training programs indicate that both psychiatrists and psychologists are not given adequate training to deal with the religious and spiritual issues that arise in clinical practice (Sansone & Rodenhauser, 1990).

Patients and physicians however, have begun to realize the value of elements such as faith, hope and compassion in the healing process. The Royal College of Psychiatrists has pointed out the irony involved in recording patients' religion, without seeking to discover what all this means to them in terms of understanding and coping with their illness (HRH The Prince of Wales., 1991). Sims, in 1994, firmly recommends evaluating the religious and spiritual experiences of our patients in assessing etiology, diagnosis, prognosis and planning treatment (Sims, 1994). The *American Journal of Psychiatry* editorial by Andreasen in 1996 stated that, ''We must practice and preach the fact that psychiatrists are physicians to the soul as well as the body'' (Andreasen, 1996).

King et al. (1995) defined ''Religion'' as an outward practice of a spiritual understanding and/or the framework for a system of beliefs, values, codes of conduct and rituals. He added that it usually involves some form of communal religious observance (King et al.,1995). The term ''Spiritual'', however, refers more broadly to a person's belief in a power apart from their own existence (King et al., 2001).

The value of such spiritual elements in health and quality of life has led to research in this field in an attempt to move towards a more holistic view of health that includes a non-material dimension. These ideas are supported by a clear and persuasive trend in the nursing literatures (McSherry, 1998; Narayanasamy, 1999).

A strong suggestion emerges that spiritual care and psychiatric treatment must, of necessity, go together. Salem, in his Spiritual Support Group, demonstrated that spirituality is a source of comfort, security, meaning and sense of belonging, purpose and strength, which promotes with religiosity a positive and optimistic worldview (Salem, 2003). Furthermore it was suggested that religious devoutness and commitment are linked positively with lower rates of depression, alcohol and drug misuse, anxiety disorders, and suicide (Koenig, George & Peterson, 1998; Salem, 2003). Interestingly, Lindgren and Coursey, in a survey of 28 *seriously ill psychiatric* patients from a rehabilitation centre, with diagnoses including schizophrenia, bipolar disorder, unipolar depression, schizoaffective disorder and personality disorder, found that 60% reported that religion/spirituality had a significant impact on their illness through the feelings it fostered of being cared for and of not being alone. In addition, 76% thought daily about God or spiritual matters (Lindgren & Coursey, 1995).

Spirituality does not fit easily with our understanding of science and what constitutes the scientific truth and there has been a tendency for psychiatry to exclude the significance of spirituality, other than as a form of pathology or pathological response. In Lindgren and Coursey's study (Lindgren & Coursey, 1995), 38% of patients expressed discomfort with mentioning their spiritual or religious concerns to their therapist, a finding backed by the Mental Health Foundation (Faulkner, 1997).

Greasley et al. (2001) believed that the domain of spirituality is a vital concern for the majority of service users. Nevertheless, participants felt that spiritual needs are not a priority for medical staff relative to more tangible issues of care. It was therefore suggested that training programmes addressing spiritual awareness be introduced and that these should be multi-disciplinary (Greasley et al., 2001).

Human beliefs are beyond scientific measurement, their precise effects, including their benefits, are therefore difficult to measure. Spiritual gains can result in partial or full transformation of the individual, serving to promote hope and the regeneration of faith in patients and carers alike. As Powell stated "When we enquire into the beliefs our patients hold, such matters deserve to be discussed with a genuinely open mind... our patients may sometimes be closer to the truth than we know" (Powell, 2001).

This study aims at exploring and measuring spiritual and religious beliefs in psychiatric out-patient clinics, and the possible impact of such beliefs on patients' coping strategies with their illness, and assessing the demographic predictors for such beliefs. Such an exploration might help in drawing the attention of Managers and Service Planners to the importance of spirituality which, although remaining a peripheral issue for many mental health professionals, is in fact of central importance to many people who are struggling with the pain and the confusion of mental health problems (Swinton & Pattison, 2001). Since the previously mentioned evidence indicates that spirituality is positively correlated with symptom reduction in different psychiatric illnesses, positive responses from the majority of our clients would emphasize the importance of pursuing the matter at hand. Moreover, this could facilitate further debate by other researchers who are interested in this area, for more advanced explorations.

Methods

The patients were given an information sheet explaining the nature of the study and a consent form to sign, should they decide to take part in our study. It was explained to them that whatever their view, they would be anonymous and under no circumstances would their care be affected by their response. Strict confidentiality was maintained and there was no chance to retrieve the patients' names or to search their psychiatric files. To avoid duplicate responses from our patients we asked them not to attempt to answer the questionnaire if they had already done so during the period of our study. It was not feasible to obtain any demographic data for those who did not take part in the study, as the Ethics Committee prohibited any attempt to do so in order to respect the non-consenting privacy. We screened all the patients attending the clinic for three months. This is the most commonly used review period allowing the screening of the spirituality and religious beliefs of a representative sample of out-patients.

Those who agreed to take part in the study were given a self-report version of the Royal Free Interview for Spiritual & Religious Beliefs to complete (King, Speck & Thomas, 2001).

The Royal Free Interview for Spiritual & Religious Beliefs appears to have satisfactory reliability and validity according to accepted psychometric standards. It contains a visual analogue scale to rate the strength with which a spiritual belief is held. High scores indicate

that respondents hold strongly to their beliefs and that these beliefs have a major role in their lives. Some of the questions allow collecting qualitative data since they have an open end to allow the patients to elaborate in their own words on their spiritual and/or religious experiences. The spiritual scale had high validity, and internal and test-retest reliability (alpha 0.81; intra-class correlation of 0.95) (King, Speck & Thomas, 1995, 2001). Furthermore it is a self-report questionnaire which is brief and simple to complete.

Setting

Clinics assessed are located at Victoria Centre, North East London NHS Trust, where there are three General Adult Consultants, two Senior House Officers rotating every six months and one Senior Registrar rotating yearly.

All the patients attending the out-patient clinic were approached, commencing from 1 March 2004, for three months. All of those who read the information sheet and signed the consent form, regardless of the nature of their psychiatric illness, were given the Royal Free Interview for Spiritual & Religious Beliefs Questionnaire to complete.

Results

Out of 103 patients screened for the study, 43 patients (42%) agreed to complete The Royal Free Interview for Spiritual and Religious Beliefs. They consisted of 33 females (77%) and 10 males 23%. The mean age for all the patients was 44.02 (SD = 12.13). The mean age for those who had spiritual and religious beliefs was 48.36 (SD = 11.35), and 39.48 (SD = 11.45) for those who did not have such beliefs; showing a statistically significant difference between the means ($t = 2.56$, $p < .05$). The main age group represented in this study was 35–54 years representing 42%, this was followed by those aged 55–64 (30%), then those aged 25–34 (28%). The majority were either married or single, 42% and 37% respectively; living with a partner, divorced, and widowed were represented by equal distributions of 7% each (see Table I).

The employment status was similarly distributed as 26% were employed, 23% unemployed, 21% were on sick leave, 16% were retired, and home managers represented 14%.

There were no statistical significance differences when spiritual and non-spiritual groups were compared, using Chi-square test, in age ($\chi^2 = 2.46$, $p > .05$), sex ($\chi^2 = 0.41$, $p > .05$), and employment ($\chi^2 = 1.30$, $p > .05$). This could be due to type II error because of a small sample size. Looking more in depth into those who have a spiritual life, the group who were aged 55+ was found to be more positively influenced by their spiritual beliefs (Kruskal Wallis 6.00, $p < .05$). Regarding the individual questions, it appears that the influence of the spiritual beliefs on everyday life was the only question that showed a significant positive correlation with age Monte-Carlo-Exact test (MCE $p < .05$).

The ethnic minorities were under represented in our study, not because they did not take part in it but rather because the study was conducted in catchment areas mainly inhabited by native English citizens. Eighty eight percent of our patients were White, whilst Black British, Black Caribbean and Indian were each 2% of the sample. Five percent of those who consented to the Spirituality questionnaire described themselves as ''others''.

As to whether or not our patients' cultural values or beliefs were taken into consideration by our service, 49% agreed that these were considered; however, 51% either disagreed or refused to comment on this question.

Table I. Demographic data for religious and spirituality study, $n = 103$.

	n (%)
Did not consent	60 (58)
Consented	43 (42)
Female	33 (77)
Male	10 (23)
Marital status	
Married	18 (42)
Single	16 (37)
With a partner	3 (7)
Divorced	3 (7)
Widow	3 (7)
*Ethnicity**	
White	38 (88)
Black British	1 (2)
Black African	1 (2)
Black Caribbean	1 (2)
Others	2 (5)
Employment	
Employed	11 (26)
Unemployed	10 (23)
On sick leave	9 (21)
Retired	7 (16)
Home manager	6 (14)
Religious/spiritual beliefs	
Religious	5 (12)
Spiritual	4 (9)
Religious & spiritual	12 (28)
Neither religious nor spiritual	17 (39)
No response	5 (12)
Specific beliefs†	
Anglican (Church of England)	16 (61)
Roman Catholic	3 (11)
Other Christian	2 (8)
Buddhist	1 (4)
Others	1 (4)
Don't observe a religion	3 (12)
Communication with spiritual power	
Communicate	15 (35)
Do not communicate	6 (14)
Unsure	2 (5)
No response	8 (19)
Not applicable	12 (28)

*None recorded for Indian, Pakistani, Bangladeshi or Chinese.
†None recorded for Other Protestant, Evangelical, Muslim, Jew, Hindu, Jain or Sikh.

About 50% of our sample considered themselves either spiritual (9%), or religious (12%) or both (28%), whilst 39% considered themselves neither spiritual nor religious and 12% did not verify themselves under any group.

The majority of our sample (61%) was Church of England, 11% were Roman Catholic, 8% considered themselves as other Christians, 4% were Buddhist, 4% categorized themselves as ''others'', and 12% did not observe a religion.

Forty two percent chose point 10 which means that they held their beliefs at its maximum intensity. Twenty six percent selected points between 7 and 9 on the scale and 16% held their beliefs intermediately at point 5 on the scale. Sixteen percent rated their views to be at a weak level and these varied on the scale between the points 1 to 4.

On responding to how important the spiritual or the religious practice is to the patient, the majority of 56% felt it to be important. Thirty five percent however, felt that practice was less important, whilst 9% expressed intermediate responses choosing the mid point on the visual analogue scale.

Sixty two percent of our sample believed that there is a spiritual power or force other than themselves that can influence what happens to their day-to-day life. However, 38% did not feel that the spiritual power would have such an impact.

Regarding the support that the spiritual power or force provides to improve the coping strategies of the patient with life events, a majority of 54% agreed that spiritual power does help whilst 42% disagreed. Four percent were equivocal about this issue.

When the spiritual power or force was linked to its possible influences on world affairs, e.g., wars or natural disasters (like floods and earthquakes), opinions were shifted to the ''no influence side'' as 54% felt that spiritual force had no effect whilst 46% believed that it did.

Forty eight percent of our sample communicated with the spiritual power mainly through prayers, less frequently through the Holy Spirit, medium, meditation, psychic power and talking to God. Nineteen percent did not communicate as such, 6% were unsure and 26% did not comment.

Forty four percent of our sample believed in life after death. They felt that they would exist as a spirit or a soul or whatever form in God's hands. Twelve percent did not believe that they would exist in any form after death, 28% were unsure, and 16% did not respond to this question.

When asked whether they had an intense life changing experience related to God, 40% did not have such an experience, 30% said that they did, 14% were unsure and 16% did not respond.

A near death experience was a rare event with only 3 patients (7%) reporting one. One patient revealed that this experience had an intense effect on his life, a second stated that it had a moderate effect and a third did not feel that it had any impact on her life. The majority of 71% did not report any near death experience, 3% were unsure, and 19% did not respond.

Discussion

In our study only 42% (43 patients) agreed to participate. The 58% (60 patients) who did not consent to the study were not sought for further data as per Ethics Committee advice regarding privacy. We could hypothesize that the non-participants (a) had no interest in the religious/spiritual subject, (b) they were too unwell or distressed to participate in the study, (c) they were not willing to disclose information about their spiritual life, or (d) were in a hurry for some reason or did not have enough time to go through the questionnaire before seeing the therapist/doctor. The fact that participants were under no pressure or influence of any kind was an encouraging factor to disclose information about their spiritual and religious beliefs.

The mean age of the participants was 44.02 (SD = 12.13). Females represented a vast majority of 77% (33 patients) whilst male participation was only 23% (10 patients). This may relate to the fact that twice as many women as men attend the clinic (Jenkins & Meltzer,

1995). However older patients appear to be more positively influenced by their spiritual beliefs, possibly through maturity and their experiences through life or perhaps they represent a generation that valued more spiritual and religious matters.

A sizable group of patients felt that their background spiritual beliefs and values were not taken into consideration in the psychiatric out-patient. This could be viewed as a form of protest against the policy of disregarding patients' beliefs, adopted by the professionals. Professionals' avoidance of matters related to spirituality and religion has stemmed from fears that spiritual beliefs may trigger or maintain pathological symptoms. Professionals may also feel overwhelmed by the increasing diversity of spiritual practices in today's society. Spirituality has received such scant attention in the research literature that any potential benefit to treatment remains empirically untouched. In contrast to the professionals' bleak perception of spirituality; spirituality can be seen as a tool for improving coping skills in managing mental illnesses through acknowledgment of the divine power in placating stressful life events. Spirituality would also provide social support and healing through religious communities. Spiritual belief can install and enhance comfort and hope so that one can succeed in life despite obstacles such as mental illness (Snyder, 2000).

A majority of our patients held their spiritual and religious beliefs strongly and felt that practicing their beliefs was important in their daily life. A substantial majority felt that the spiritual power or force does not only influence what happens to their daily life but also has a positive impact in improving their coping strategies with life vicissitudes. Our finding is in line with recent research which has documented the positive role that religious belief can play in helping people cope with significant life-alerting events. Maton (1989) believes that spiritual support, like social support, can have beneficial stress-reducing effects. Maton suggests that spiritual support operates through two pathways; cognitive mediation and emotional support. Cognitive mediation refers to the positive interpretation and appraisal of the meaning and implications of negative life events. The emotional support pathway includes the perception of being valued, loved, and cared for by God (Maton, 1989). Furthermore, systematic reviews of research literature have consistently reported that aspects of religious and spiritual involvement are associated with desirable health outcomes (Swinton & Pattison, 2001); in addition spirituality has been positively correlated with symptom reduction in depression, anxiety, addictions, suicide prevention, anorexia and schizophrenia.

The majority of our patients disclosed their regular communication with the spiritual power mainly through prayers and believed in life after death. A substantial minority reported an intense experience with God which gave them a new meaning to life. The near death experience is a difficult and a private experience to interpret. However it is understandably an intense experience with a particular meaning and effect on the life of those who experience it.

This study highlights the fact that religion, faith, and spirituality are fundamental dimensions of human experience and essential components of one's identity (Wilson & Moron, 1998). Questions of meaning, purpose, and one's personal significance or worth are at the core of spiritual and religious concerns. Life events and experiences, especially those which are uncontrollable, difficult to manage, and life altering can seriously challenge one's sense of meaning and purpose in life. Recovering from life changing experiences and illnesses often requires a reordering, rethinking, and renewed reliance on the sources of meaning, purpose, and significance in the individual's life. Recovery often requires both psychological interventions to help people gain control of their lives and religious or spiritual understanding, to help them come to grips with the limits of their control (Paragament, 1996).

It is equally important to note that spiritual assessment also raises areas of concern. Professionals must strike a delicate balance between using and developing patients' spiritual strengths and remaining focused on the present helping task. The point of therapy should always remain on directing resources to ameliorate the presenting problem. Professionals should avoid falling into the role of spiritual directors in which they assume the role of a spiritual expert directing patients in their spirituality. In addition, some practitioners may hold certain values so firmly that they risk imposing their beliefs on patients, in which case they should refrain from undertaking spiritual assessments with populations that are likely to hold differing values. Furthermore, spirituality is a private matter for many patients, and subsequently some may refrain from exploring this area in a clinical setting. Therefore tactful approach should be considered when tackling this area, and the clinician should carefully monitor the patient's responses to ensure that autonomy is respected throughout the assessment.

The research in this area is very sparse and despite the new innovations in psychiatric assessments and treatments the work in the spiritual field is still lagging behind and intermingled with pejorative connotations of primary narcissism, irrational thinking, and emotional disturbance. Professionals have yet to acknowledge their lack of training and shortage of knowledge in the area of their patients' spiritual beliefs and needs; which was acknowledged long ago by the Royal College of Psychiatrists as an important means in helping our patients in understanding and coping with their illness. The shortfalls in this study are the relatively small number of participants and the fact that it was conducted in a catchment area inhabited by a homogenous native Caucasian population; perhaps conducting a similar study where there is more heterogeneous population from different cultural, ethnic, religious backgrounds and how professionals encompass such differences could have furnished us with more information about the impact of these differences on patients with mental illnesses.

Further studies and research in this area are very much needed not only to address the values and beliefs of the patients but also to equally explore those of the professionals. This would help to foresee a mutual and respecting therapeutic alliance between therapists and their patients.

Clinical implications

- The study highlighted the need for including the spiritual and religious needs of our patients when collectively approaching their mental illness.
- A sizable group of our sample felt that their spiritual needs were not addressed when attending different therapeutic sessions.
- Further exploration of this area is necessary to expansively investigate the spiritual needs, not only of the patient, but also from the carer's and professional's perspective.

Acknowledgments

The help of the reception staff in the Victoria Out-patient Clinic was much appreciated.

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